VERBATIM PROCEEDINGS

DEPARTMENT OF PUBLIC HEALTH

CONNECTICUT HEALTH INFORMATION TECHNOLOGY AND EXCHANGE

DR. JEWEL MULLEN, CHAIRPERSON

JANUARY 7, 2013

101 EAST RIVER DRIVE
EAST HARTFORD, CONNECTICUT

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. . .Verbatim proceedings of a meeting in the matter of Connecticut Health Information Technology and Exchange, held at 101 East River Drive, East Hartford, Connecticut on January 7, 2013 at 4:36 P.M. . . . .

CHAIRPERSON JEWEL MULLEN: Any discussions, edits, clarifications, anything? No, okay. So, all in favor.

ALL VOICES: Aye.

MS. BETTYE JO PAKULIS: I'm going to abstain, I wasn't here.

CHAIRPERSON MULLEN: Okay. Any other abstentions? Alright, we can move on then to the Treasurer's report.

MS. CHRIS KRAUS: Okay. I sent by e-mail the financials, which includes the balance sheet, revenue and expenses, unpaid bills and a cash flow document. We have $611,219.81 in our Webster Bank account. We have total liabilities of $2,548,620.50, and those are payments due to Axway, which leaves us with a total equity of a negative of about -- negative $1.5 million.

From July 1st of this year through December 31st, we have revenue of $292,250. Total expenses from that same time period is about $2.3 million and because our accounting system is on the accrual basis, that includes those invoices that were sent to us from July 1st to December 31st. Unpaid bills remains the same as the last couple of months and that comes out to be $2,548,620.50, all due to Axway. We are current on all our other invoices and our cash flow. Our actual costs for the month of December were $32,514.35.

You might notice that our payroll expenses are a little higher than last month. That's because we have caught up on our 401A matching, which was a little less than $7,000. Any questions?

MR. BRUCE CHUDWICK: Did someone else just join the call?

MR. MARK MASSELLI: Hi, it's Mark Masselli.

MR. CHUDWICK: Hi Mark.

CHAIRPERSON MULLEN: Happy New Year Mark.

MR. MASSELLI: Happy New Years as well.

CHAIRPERSON MULLEN: Thanks. So if no questions, no comments, Chris, thank you. You do it very nice, easy to follow, clear --

MS. KRAUS: Thank you.

CHAIRPERSON MULLEN: -- and I think reflects all the changes and modifications that people are asking for. No matter what the bottom line shows they're still very good documents.

MR. CHUDWICK: You need a motion to approve.

CHAIRPERSON MULLEN: Yes, a motion to approve the Treasurer's report.

MR. DANIEL CARMODY: I make a motion to approve the Treasurer's report.

MR. STEVE CASEY: Second.

CHAIRPERSON MULLEN: Thanks. So -- Hi Dan.

MS. KRAUS: Who seconded?

CHAIRPERSON MULLEN: Dan, and Steve Casey seconded. Did somebody else just join?

MS. BRENDA KELLEY: Brenda Kelley.

CHAIRPERSON MULLEN: Hi Brenda.

MS. KELLEY: Hi.

CHAIRPERSON MULLEN: So all in favor, we have a motion and a second to approve.

ALL VOICES: Aye.

CHAIRPERSON MULLEN: Abstentions, nays? Okay, that's good. Alright, so we need a motion to move into executive session.

MR. CHUDWICK: Next item is executive session pursuant to Connecticut General Statutes Section 1-200B-6, regarding strategy negotiations with respect to a pending claim with Axway -- the Axway contract. This requires a motion, a second, and approval by two-thirds vote of the Board.

And the motion should include those who are invited in to the executive session to provide testimony and opinion related to the matter. So is there a motion to go into executive session?

FEMALE VOICE: Motion.

MR. CHUDWICK: Who seconded?

MR. MASSELLI: I'll second.

MR. CHUDWICK: Seconded by Mark. Any discussion? Those invited into executive session will include myself, Marianne Horn, I think we have some folks from Updike, Kelly & Spellacy joining us.

MS. JOAN SOULSBY: Joan Soulsby from OPM.

MR. CHUDWICK: Joan, okay. Anyone else to invite in?

MALE VOICE: Mark Brandon might be showing up, I'm not sure, so if you could include him.

MR. CHUDWICK: Okay.

MR. JOHN DeSTEFANO: Dr. Tikoo.

MS. BARBARA PARKS-WOLF: Also, Karen Buffkin may be coming late.

MR. CHUDWICK: Okay.

MS. KRAUS: John and I.

MR. CHUDWICK: Yes. Okay, there's a motion and a second --

CHAIRPERSON MULLEN: Vanessa Kapral.

MR. CHUDWICK: Okay, any further discussion? All those in favor of the motion to go into executive session please signify by saying Aye.

ALL VOICES: Aye.

MR. CHUDWICK: Those opposed say no. Any abstentions? Motion is carried and we're in executive session with those people invited. It's 4:42.

(off the record -- executive session)

CHAIRPERSON MULLEN: So we're back on the record.

MS. KRAUS: CTO update, other business, update on Board vacancies and the meeting schedule for 2013.

CHAIRPERSON MULLEN: Okay, so I've provided a list of vacancies that require gubernatorial appointment to the appropriate people who are on the Governor's staff. I know that Melissa Stein, who was actually a person I

think Chairing that work or overseeing that --

MS. PAKULIS: She was administrator for -- yes.

CHAIRPERSON MULLEN: -- administrator, has moved on and someone else has come in. For some of the other vacancies, for example the appointments by the Speaker of the House, have been on hold because we just had an election and we were waiting for the new designees. So I'll be having my executive assistant liaison follow up on some of those. I think that we'll have some other information about sustained Board membership once we've also clarified the second item there, which is the Board meeting schedule.

I think that's about it for now. Thank you for those -- you know, you had provided some names for some people that I did send forward, so it's I think just a matter of following and pursuing it. I would say most of December was lost just as a lot of people's including mine, attention was shifted to what was happening with Newtown and Sandy Hook, so.

MS. PAKULIS: And we don't have a meeting of Boards and Commissions this week but we do next week --

CHAIRPERSON MULLEN: Okay.

MS. PAKULIS: -- so I'll make sure and

bring it up next week.

CHAIRPERSON MULLEN: Thanks.

MR. CHUDWICK: Chris, do you want to talk a little bit more about the Board meeting schedule, the survey results -- what the survey says?

MS. KRAUS: Sure. This will be challenging. I sent out a survey and the problem is lots of folks have commitments. One other thing to add to what I sent out is that Angela Matte is now teaching a class on Thursday nights. So as I mentioned previously, the preferred night seems to be Monday. We do have Commissioner Bremby who cannot attend on Thursdays, we also have Ron Buckman who cannot attend on Thursdays, and now we have Angela.

So we have an issue with what night. Does anyone have any suggestions?

DR. RONALD BUCKMAN: Yeah, this is Ron Buckman.

MS. KRAUS: Oh, hi Ron.

DR. BUCKMAN: Hi. Yeah, I don't know if it makes a difference but if it's on Thursday if it's starting at 6:00, I can do it. It's just if it's starting at 4:30, I cannot.

CHAIRPERSON MULLEN: I can read your facial

expressions and as you can imagine I think a lot of people are saying and thinking oh, not that late. I understand. I might have to --

MS. ANGELA MATTIE: -- I teach till 5:15 on Thursdays and only till the first week of May.

MS. KRAUS: Does anyone have a suggestion? I know that there were several people wanting to do it during the day but I know Dr. Mullen, you said there was no way you could commit to a set time during the day.

CHAIRPERSON MULLEN: It's just the way my schedule works. It's going to be -- you know.

MS. PARKS-WOLF: Didn't we explore early morning?

MS. KRAUS: I threw that out and there was no consistent response, you know, would anyone want 7:00 in the morning, a breakfast meeting.

CHAIRPERSON MULLEN: Was there a daytime that worked for most people?

MS. KRAUS: No. People had just wrote daytime and it was all over the place, so if anyone wants to throw out a suggestion. I think the real issue is if we keep it on Mondays we have Commissioner Bremby, who really would like to attend who can't do Mondays at all. And once again, Ron Buckman said he can't do Mondays until

6:00.

MR. MARK HEUSCHKEL: My comment is I would just like to advocate on behalf of my Commissioner it not be on Mondays if at all possible.

MS. KRAUS: Right.

MR. HEUSCHKEL: I think that is important.

MS. KRAUS: We did think it was important to include him.

MR. DeSTEFANO: So given this information then should we -- I don't know if it's worth doing another -- to send it out again?

MS. PARKS-WOLF: And Tuesday -- oh, you can't do it, no.

MS. KRAUS: So Tuesday, I think Dr. Mullen you said you could not do Tuesdays unless things have changed. And I had one other person who didn't put their name in that could not do Tuesday. Commissioner Bremby said he would make himself available to meet any time other than Monday afternoons after 4:00 p.m.

CHAIRPERSON MULLEN: Ahum.

MS. KRAUS: He could meet early or late Tuesday through Friday or earlier on Monday, so I don't know if there is any availability during the day. I know a lot of other Boards do meet during the day, Health

Information Exchange has all their meetings during the day.

MR. DeSTEFANO: Insurance.

MS. KRAUS: I'm sorry, Health Insurance Exchange.

MR. HEUSCHKEL: I think if we -- my -- I mean if enough people agreed -- I mean I don't -- if people were available to meet during the day the key would be to just have a normal routine --

MS. KRAUS: Right.

MR. HEUSCHKEL: -- meeting time. I think initially people responded to this because everybody's booked with other things, so. I mean, I would advocate that but --

MS. PARKS-WOLF: 2:00 on Monday, every Monday?

MR. HEUSCHKEL: Monday is not a good day.

MS. KRAUS: Because I had only one person who said they could come before work, I had two people that said they wanted to come during the morning, 9:00 to noon, two people during the afternoon, and eight people at the end of the day. So it was really all over the place.

Does anyone want to throw out a suggestion and see how that goes over?

MS. PARKS-WOLF: Saturday?

CHAIRPERSON MULLEN: So I can work with my secretary and see if we can move some things around for Tuesday. Wednesdays are bad and as you see, the way things go for me there are times when I really need a designee.

MS. KRAUS: Is there anyone else that can't do Tuesday at 4:30?

CHAIRPERSON MULLEN: Does that mean everybody else is willing to do Tuesday at 4:30?

MS. PARKS-WOLF: It's a better day for me.

VOICES: Yes.

CHAIRPERSON MULLEN: I have a very happy person who does my schedule, I'll just go and make her happier tomorrow.

MS. KRAUS: So you'll reach out to see if you can change it, thank you Dr. Mullen.

CHAIRPERSON MULLEN: And any particular Tuesday?

MS. KRAUS: There was no preference as far as the week of the month.

CHAIRPERSON MULLEN: Alright, so we have to change three schedules in my office to try to do it so let me check.

MS. KRAUS: Okay thank you, I appreciate that.

CHAIRPERSON MULLEN: The other option is for somebody else to be the Board Chair.

MS. KELLEY: Excuse me, this is Brenda. I am able to do some Tuesdays but there are four Tuesdays in the year that I am not able to because I'm on another Board that meets at that time.

CHAIRPERSON MULLEN: Do they fall on a particular week of the month?

MS. KELLEY: In February, April, it's Tuesday -- I don't know because I'm on vacation but I know the first meeting is Tuesday, February 26th, so whatever Tuesday that turns out to be. I think they picked that particular sequence for April and June and September.

MR. MASSELLI: It sounds like the fourth Tuesday.

MS. KELLEY: Probably yes, that's what it looks like.

COURT REPORTER: Can they just identify who they are --

CHAIRPERSON MULLEN: Brenda Kelley.

COURT REPORTER: --and?

CHAIRPERSON MULLEN: And was that Dan?

MR. CHUDWICK: Was that Dan or Ron?

MR. CARMODY: I'm okay, I mean if you just give out a date I'll try to work whatever I can.

MR. CHUDWICK: That's Dan.

CHAIRPERSON MULLEN: Is this also going to affect the Executive Committee meeting time?

MS. KRAUS: We haven't set that either.

CHAIRPERSON MULLEN: Okay. I think we're down to four people for the Executive Committee.

MR. CHUDWICK: Unfortunately Commissioner, I think by statute you are designated the Chairperson of the Commission.

CHAIRPERSON MULLEN: I know.

MR. CHUDWICK: Well, you said someone else could be Chair.

CHAIRPERSON MULLEN: How about strike that.

MS. KRAUS: So Commissioner, you'll go back and check your schedule for Tuesdays?

CHAIRPERSON MULLEN: Mine and two other people's.

MS. KRAUS: Okay. And Brenda, you thought it might be the last Tuesday --

MS. PAKULIS: Quickly I just looked, it is the fourth.

MS. KELLEY: It looks like it's the fourth Thursday. As I said, I'm on vacation so I don't have all my records here.

MS. KRAUS: Okay.

CHAIRPERSON MULLEN: Thank you.

MS. KELLEY: Yeah, thank you. And I'm going to have to sign off. Are you going to be voting on anything that you need a -- that I'm essential for a quorum?

MR. CHUDWICK: I don't think so Brenda.

MS. KELLEY: Alright, well thanks everybody.

CHAIRPERSON MULLEN: Enjoy the rest of your vacation.

MS. KRAUS: Thank you Brenda.

MS. KELLEY: I will, thank you. Bye bye.

MS. KRAUS: Okay.

MR. CHUDWICK: So what the Board may want to do is to set the next meeting as a special meeting until the regular meeting schedule is adopted by the Board that can be filed with the Secretary of State and then go back to regular meetings. Technically this meeting today is a special meeting, which just means you cannot add anything to the agenda, and pending a regular meeting

schedule being adopted then that's what I would suggest the Board do, so.

CHAIRPERSON MULLEN: Okay got it, thank you.

MS. KRAUS: Okay, so when will the next meeting be?

CHAIRPERSON MULLEN: I'm not going to be able to answer that right this minute.

MS. KRAUS: Right, so should we wait to hear from you and then schedule the next meeting -- okay, thanks everyone.

CHAIRPERSON MULLEN: Agency business.

MS. KRAUS: John, you're on.

MR. DeSTEFANO: Okay. Ron, are you going to stay on the phone?

DR. BUCKMAN: I can be on for about another 10/15 minutes.

MR. DeSTEFANO: Okay, because I -- if you want to stay I have a presentation here probably -- you know, in the interest of time I hope we'll get through it in 20/25 minutes, but I can send it to you after this then.

DR. BUCKMAN: Thank you.

MR. DeSTEFANO: Okay. So at the previous

meeting the Board had asked me to prepare a Strategic Plan or a change to our Strategic Plan to move the organization forward. And again, I took a lot of input from various members of the Board and from Minakshi and Chris and I put this together. So it is not a sum total of everybody's opinion. So in effect that's what it is really, is what I think and what I think should be our Direct report. I'm going to see if I can shut the lights off.

MS. KRAUS: John, do you want to speak into the phone.

MR. DeSTEFANO: I'm going to have to -- just move the phone. So moving forward and just for those on the phone, we have a picture of a mountain in front of us. And in my past seven or eight months here at HITE/CT -- you know, my opinion definitely started on the opposite side of this. So, you know, as far as a mountain goes it always looks further than it is. It's always taller than it looks and it's always harder than it looks.

So with that in mind -- I mean, I think we can all say for sure that this probably isn't what we thought when we first started. I know it certainly isn't what I thought the job would be and the way forward would be. But people climb mountains all the time so we need to climb this one. Before we can start I think we really

need to take a look at where we've been and why it hasn't worked. So we started off with a utility model and for those not real familiar with that, think about what HITE/CT started a year and a half ago with the model we put forward in this state. It was what ONC refers to as a utility model, everything deployed to the cloud, you know, standards-based, easy for everyone to plug into.

So I think at the time, since I was on the other side of the table from HITE/CT at the time, I do remember various people from HITE/CT and from this Board coming forward and discussing that. And I think the general impression was well, why wouldn't you do it? It sounds pretty easy, it is standards-based. The components that you would use to plug into this should be reusable if you had a big IT shop like a hospital or something like that. You should be able to reuse them inside your own shop. It didn't work and it didn't work for a number of reasons. I think prior to the -- part of the premise on this was this is the way we're going to go and this is how much it costs. And the customers, although they did say they think it's a good idea, I don't think you would go to anybody in the state, a hospital provider, anybody who would say that this is not a good idea.

But the return on investment form was the

issue and the model that came forward from HITE/CT was not a model that they were comfortable with. You know, along with that too -- and which is still the case, the market readiness. Although you can plug into what we had put up in the cloud pretty easily because it is all based on standards, the market in general wasn't really ready. There aren't that many hospitals in the state who are ready to do this, frankly there are very few. And from the provider office perspective and the large providers, again, there are very few who are really ready to do this. So we're still -- at least in Connecticut, you know, we have a ways to go in our marketplace before we're really ready to move forward with this.

Part of the issue, premise of HITE/CT is, you know, its name. It says Health Information Technology Exchange of Connecticut. And I really firmly believe that this problem is less about technology. I think it's, you know, in some ways the name. It doesn't really reflect what we should be doing. This is a business problem. Unless we can go out to our business customers and give them what helps them, some return on investment for what we have, some improvements to their work flow, some future that they can see in all of this, that's what we have to give them. Giving them technology, this is commodity

technology now. It's been commodity technology for awhile. After about 2005, Health Exchanges existed all over the place and they were dissolved all over the place too. It was never about the technology and it still isn't.

The technology can be purchased. It doesn't have to be from HITE/CT it can be from any vender, and in fact a lot of the hospital systems in the state are moving forward with standing up their own local Exchanges. Not something that's contrary to what's happening in other parts of the country. And our message -- not to be critical but the message I got when I first met with HITE/CT, I think it was at a CIO meeting, and CHA was here's the bill, here's how much it's going to cost, here's what your part of this is. And again, that doesn't talk to what we need to be about and that's helping our business partners, our stakeholders, solve their health care issues, helping them connect to other providers, helping get and stimulate Health Information of Connecticut to start moving.

So what do you guys think of the presentation stuff so far? It's pretty neat isn't it?

MR. CHUDWICK: I just got this today.

MR. DeSTEFANO: It's a lot of technology.

So I sent -- I think it was about 5:57 this morning or something, I sent you my PowerPoint presentation then I said ah, it's kind of dull and boring so I'm going to try to do it up a little bit.

CHAIRPERSON MULLEN: Somebody told me that their five year old taught them how to do this. It really moved them out of PowerPoint into the new realm and I'm still trying to learn it, so.

MR. DeSTEFANO: It's pretty neat.

CHAIRPERSON MULLEN: No, it is.

MR. DeSTEFANO: Doesn't take that long to do it. So let's go back for a second. So what about our new approach? This is truly the attitude I think we have to have and it's certainly my attitude. Forget about the consequences of failure. Failure is only a temporary change in direction to set you straight for the next success.

As Commissioner Mullen mentioned earlier, we need Health Information Exchange in Connecticut and I do firmly still believe or frankly I wouldn't be here, that some organizations in the state needs to carry that bear and move it forward. You know, you can certainly foresee situations in the state given the way things could potentially grow organically, that we could have a very

confused and frankly very expensive problem to solve in the future unless we get it right out of the gate. And I think that's what we need to focus on now. So what's going to drive us to success?

Some key elements -- and I borrowed these from Massachusetts actually. So vision organization and strategy, and strategy in this case is choosing not necessarily what to do but what not to do. So what is our environment here in Connecticut and what is it that we need to do to stimulate Health Information Exchange and to make Connecticut -- help Connecticut have a learning health environment? So -- and again back to that thing about what our customers, I think frankly from discussions with them and even from discussions with Health Information Exchanges in other states, customers don't want a quarter inch drill bit they want a quarter inch hole. So it's not about the technology. It's not about how the hole gets put there it's about the hole. And that's what they're looking for from us. So our approach is we use technology to improve current work flows, that's an approach I think we need to start looking at.

Initiate or participate in projects which are uniquely positioned -- which we're uniquely positioned for, and we are a quasi-public so we do sit someplace

between the public and the private sector. And although sometimes that's a challenge, it does put us in a unique position because frankly you can see where customers could potentially trust us because we're sort of in between. We're really not on the public side and we're really not on the private side. So we are uniquely positioned for certain I think key elements of exchange going forward that Connecticut will need. It will not only need it for internal purposes for the public and the private sector to be able to talk to each other, but there will come a time when the federal government is going to demand of that we as a state be able to communicate with the federal partners also and other states.

So what's feasible and how do we figure out what's feasible for us to do? You know again, it goes back to it's based on demand, it's based on available technology and what we can potentially bring to the table around that infrastructure question, policy. So it's always policy does drive a lot of decision-making, and market substitutes. Do we have something that can't be substituted for? Is it easier for our customers, potential customers, to get it from us, or is it easier for them to just buy it themselves. And so these are the questions that we need to sort of figure out going forward

to have some strategy. And I'll go quickly because in the interest of time here, I know it's late.

So what about our stakeholders? We've had discussions about it before. I think I said a number of times before we need to go and reengage them. That's not as simple as I thought it would be frankly. It's hard to get people's attention. They are busy on many other things. I know from the hospital CIO perspective, all the hospitals have a lot of agenda -- a big agenda ahead of them with meaningful use and changes in the system. And that goes for the large provider organizations in the state too, everybody's busy. So we can't just make random sales calls. I do remember when I was practicing pharmacy, you know, the drug reps would walk in all the time and walk behind the counter and -- you know, we've got this new thing. And we can't do that, we have to be strategic about how we go about this. We have to be targeted and focused on our objectives. When we do have a chance to get in front of customers we need to give them some valuable information.

So our stakeholder group, like I said we're public and private. We have -- those are our stakeholders. Certainly on the public side we have a contract with DPH to do various items around meaningful

use, which we're actually going to get to. And the Department of Social Services definitely has a need going forward to manage their patient population better. So, you know, in our state who is better positioned frankly as an organization to move those agenda forward than us? And again, we have a lot of potential customers out there so certainly the hospitals, nurses, VNAs, private practices. And one of the things I think we don't maybe talk about enough is this group in the middle, and those are the people of Connecticut, the patients that we're supposed to be serving.

You know, we worry a lot about taller types of organizations, issues we're having, but we need to focus back on what the mission is. And the mission is to provide better health care for the people of Connecticut. I think that even from the ONC perspective that's why we got granted the money, to make the health care system better. Possible areas of opportunities, which I've talked about before with these stakeholders, so those are Direct services. And we've talked about us being a Health Information Service Provider or HISP, we've talked about provider directories, we've talked about marketplace frameworks to put a Direct marketplace in Connecticut. The -- you know, what HITE/CT initially wanted to do was

around a query response type of model that hasn't frankly worked out well. But many other states are having success with it as they look at the local and regional exchanges in their state and how they're going to connect those together.

We were just in Rhode Island last Friday. Now, Rhode Island is not a quasi-public, it's a dot.org, very well organized. It's been run for awhile, are very much self-sustained right now, have a whole different model outside of all of the standards that we've been talking about. So, you know, I am a technology person at heart so those standards are important to me. I still think they're important going forward but we can look at other ways frankly to move this forward. And in a way, you know, we haven't spent as much as we thought we were going to spend right now. But in a way that's not a bad thing because we're already seeing from meaningful use stage two, every EHR vender needs to have Direct built into their system. Rhode Island is leveraging that. They have signed up five venders now and they have another five on the list for this year, to be able to send Direct messages right to their Exchange.

So take out the whole layer of that technology, a whole big part of the expense and do it at a

reduced cost because the federal government is driving the venders to be able to provide this kind of technology right into their system. So in fact if we had went with out original plan and we had deployed those activators every place in all of these organizations, it would have frankly cost us a lot of money. And having managed very large infrastructures before, it would have been a nightmare to manage. I think that's a given. All of these point-to-point connections would have really been an issue from a management perspective and we would have put a lot of resources into it. If we wait another six months that might to a large part, all go away.

So although we're behind the eight ball here and we should have had a lot of stuff done already, in fact from a cost perspective it might not be such a bad thing that we've lagged behind somewhat. So things to consider, and we mentioned this earlier, the runway is getting short. You know, as far as should -- you know, my own perspective again, and certainly everyone around here I'm sure has their own perspective. If we wait too much longer to do anything, if we are afraid because the issues that we're having with our vender right now we'll run out of time. These things don't grow over night and that's been a lesson from every state that we've gone to, that

this takes awhile to do. So we -- the time really is now. There is an urgency to getting this moving forward.

You know, and a way to stimulate it, perhaps learn certainly from the lessons of others, but if you can find a friend in your neighborhood who might be interested in helping you out then I don't see any problem with doing that. And certainly -- you know, as I said we've talked to the Rhode Island guys who were very interested frankly in some partnership with us. And certainly, something that we need to consider going forward. And again, as Commissioner Mullen mentioned earlier from a state perspective we're not -- it's not really clear where HITE/CT fits right now. We haven't defined that yet. I think it's a lot easier to go to stakeholders and talk to them when you have something in-hand.

So if we had some successes in-hand, if we said we deployed Direct to some of these behavioral health organizations or something -- you know, like something like the state large provider group, connected some hospitals, connected some long-term care facilities, it's a lot better position that you would go to stakeholders with if you had shown some successes. And I don't think -- frankly it may take a little time. And being an IT

guy, I do count things in IT weeks, so a week is like really a month. But I don't think it's going to take that long given a reasonable strategy to move this forward a little bit and quickly. And that will give us a lot of credibility with our stakeholders.

Yeah, so here's the -- you know, certainly the contract issues. Our organizational structure, we mentioned that. You know, should we -- should there be a different organizational structure? A hard problem to solve, there's a lot of political ramifications to that. There's a lot of policy ramifications to it. You know, the market competition is difficult as a quasi, at least that's my belief, because of us having to frankly expose everything we do and we are very transparent. And that's part of being a quasi. Some other businesses frankly can move things differently and they don't necessarily have to provide their business strategy out to the public. That in a competitive marketplace that can frankly not be the greatest position to take. And I put monopoly in quotes here for the HISPs. They're really not a monopoly but for that type of service in Connecticut, who else are you going to do business with?

So -- you know, they have pretty much a captured audience. For us every hospital in the state can

do what we have, can do what we can do, every provider organization within their own organization can do what we can do. So I think our place there is in between those organizations and we have to help the organizations through the connect. For us to get in and say we're going to provide this technology for you to use in your organization, they can buy it. It's a lot probably cheaper than we can provide it to them for.

We have a Regional Extension Center in the state that's run by a dot.org, so we have two organizations in the state that are not necessarily doing the same thing, but certainly involved in the health care arena. So if you think about that and think about that issue of a runway, two organizations combined like that could potentially leverage each other certainly and get more runway out of the grant money and potentially come up with a strategy that will work both on the deployment of technology and providing services to providers and the actually infrastructure and business problem-solving aspects that HITE/CT could bring to the table. So there might be -- in my mind anyway, you know, that is a potential direction. Certainly it's out there and many other states have done it.

Again going back to Rhode Island, we've

been there. They have the triple threat there as ONC calls it or triple play. They have the same organization as the Health Information Exchange. It's a Regional Extension Center. It's a Beacon grant recipient. Same up in Maine, two of the most successful Health Information Exchanges in the country frankly. Maine is one of the most successful Health Information Exchanges in the country. It's a dot.org company, it is a triple play. They have all three of those grants and they're very, very successful.

So immediate recommendations, and this would be in the one to three month period. So we need to update our Strategic and Operations Plan and submit that back to ONC because frankly if we don't then our issues with our vender are a moot point. Reengage stakeholders around issues that are important to them, so things that make a difference, certainly common issues around privacy and security. That makes a difference to them because as they stand up these things they don't want make sure that they step over the line with their policies on privacy and security and so we'd like to be part of the conversation so that we can bring the whole community together around this. So that we wanted to target, and I have some other action steps here. But we'll target, you know, specific

conversations around those issues that seem to resonate with our stakeholders.

Some demonstration projects, the IAPD grand, which ITT hopefully will play a role in for the Department of Social Services, and then we need to again address our organizational structure. So how are we going to achieve those objectives? The ONC Strategic Plan as I said, the Privacy and Security Advisory Committee, thanks to Ellen and others on that Committee, we are setting up meetings with it to start at least with those organizations in the state that intend to or already have functional Health Information Exchanges but are private Exchanges. So we want to visit them. We want to know what their privacy and security issues are. We want to know what their consent policy is and we'd like to know how they educate their patients and maybe bring all of that information together from a community perspective so that others can leverage and gain some value off of it.

Now, is that a sustainment strategy? Not really. We're not going to get paid for that but there are things that need to happen on the ground to build a foundation before we can really build anything on top of it that we can actually look to to sustain us. And I believe this is part of that strategy. And Commissioner,

you know, a formal plan to examine the current state of HITE, the structure of HITE/CT, we'll hear more about that going forward. I don't really know what that is, I don't know if we should put together a Subcommittee of the Board or Task Force to examine that or if we should wait until our issues with Axway hopefully have been resolved. But certainly, we'll definitely -- we need to look at this.

And so as part of this plan I'll come back to you guys and say what do we need to do? How can we move that agenda item forward? We already have some buy-in from DSS to do a readmission rate reduction demonstration project. Now, think how valuable that could be to our Medicaid population in the state and what a cost saver that could be. Readmission rates are -- or readmissions are extremely expensive, and so we have a plan that we'd like to partner up with the Department of Social Services on to move forward with. The IAPD grant, we've already -- you know, we talked about that and we are still working on that so that's immediate. Capacity building may not -- I know it's not a term that everyone is familiar with but what does it mean?

So capacity building, again, is one of those ONC models and as we've tried to learn from others a lot of states have a lot of success with capacity building

and I'll explain what it is in a minute. But initially, the initial submissions to the ONC around plans, what people had put forward to do. Only six states had capacity building as part of their plan now over 21, and that number grows all the time at the state HIE level. So capacity building is becoming a key strategy for a lot of Health Information Exchanges. We're not alone in the fact that we aimed high and the market really wasn't in line with our initial projections or what it was. Almost every other state frankly did that.

But they've learned and now it's time for us to learn and to learn from them and what they've found to be successful in the marketplace. And this is certainly one of the strategies that has been found to be fairly successful and Rhode Island has used this strategy and a number of other states. As I said, there are 21 currently who have capacity building plans in place with the ONC. So we're going to focus on short-term objectives. Part of this is a giveaway and we need to stimulate providers, hospitals, to make connections to each other. And part of that way we're going to do that is to provide some funding for them to do it. So that might be a certain number of months of free, maybe direct service. We'd like to go out and look at some of the

venders out there who the larger systems have for their EHR venders and see what might be done to help those venders get to a point where they can connect using, again, Direct.

Rhode Island had a very -- and we've heard both Rhode Island and Maine actually, their EHR venders. Currently there's five on the list, they are well known and large venders. And they have funded them to put assets into their EHR to be able to connect to the Direct infrastructure of Rhode Island. So that’s very good news for us because those five we could take off the list, Rhode Island already paid them. So we need to go out and find the ones in our state who are most used by our provider community and let's see if we can help them fund some of their efforts to get Direct built into their EHR quickly so that we can move forward quickly in Connecticut. And as I mentioned earlier -- as I said, there are 21 current programs in the country.

So the capacity building model from ONC had this bolstering of state -- of sub-state exchanges through financial and echo support tied to performance goals. So we're just not going to give money away. You know, we have to have agreements in place with those who want to participate in this that -- you know, for instance

Oklahoma has a funding plan for their providers but they'll give the providers a voucher basically for a year free of Direct. Oklahoma has a Direct marketplace, they could pick any vender in the marketplace but they have to do it within 90 days. And we would certainly want to put something like that in place because again, the purpose of capacity building is to stimulate something over a short period of time and get a -- try to get the largest network effect that we can get. In other words, get the most people connected that we could possibly get connected over a short period of time.

Some of the -- we meet these preconditions certainly, you know, sub-state nodes exist. And there are Health Information Exchanges around the state, they're private, and that's what the sub-state nodes means and those are not connected. There isn't any Health Information Exchange currently in Connecticut that's up, and there are only a few right now anyway, that is actually communicating with another Exchange. And there isn't any existing statewide Exchange entity, we're it. So this is something that -- you know, certainly a service that we should perform. Okay, so how are we going to do it? The RFI which we talked about before, I think we put that out, and that’s not necessarily that we would be a

HISP. I don't think we want to be a HISP. There's only two of us frankly here right now and it does cost money to operate a HISP.

That was one of our issues with Axway frankly, is the model that was put forward required us to hire people and there are a number of other activities that we would need to perform that would cost us money. So there is a way to go about this that's frankly very inexpensive to do and it doesn't require a lot of resources from the Exchange's perspective. So the RFI is a first step at finding out what other venders are out there potentially that might want to participate in this and establish a direct marketplace in Connecticut. We had extensive discussions Friday -- they weren't too extensive. I think -- actually they weren't that extensive at all. It was a couple of hours and everybody at the table agreed that this would be a great thing for both of us.

But we would like to and this is my recommendation, we partner up with RIQI in their marketplace, in their Direct marketplace, so Connecticut joins. They are -- and along with that we adopt the Directtrust.org accreditation, which is starting in February. That's another thing that Rhode Island intends

to adopt. So Directtrust.org is -- will become an accreditation body in February and it will be -- frankly across the entire country, a great thing to be in. It will solve a lot of our issues around us having to maintain our own policies and procedures and marketplace documents around all of that. You know, it could be as simple as the agreement is, you want to be a Direct vender in our marketplace you have to be accredited by Directtrust.org. That accreditation will include both the technical and the policy aspects of being a HISP or HISP service provider.

So I think it's just a lot easier and it makes more sense but a lot of states are moving away from the programs that they currently have in place to go for just Direct accreditation. Once the Direct accreditation is in place and it catches on the whole ability to move data across state lines, to have all of the security in place, is going to be a lot easier. The provider directory is something that I do believe there's a market for. Before we would move forward gung ho with that we would actually need to go out and get some partners and say, you know, you think it's a good idea, we think it's a good idea, we think this is how much it's going to cost us, what part of that are you willing -- what part of that

do you think you might be willing to help us fund.

So definitely a provider directory is important in the state. I think it will be important for the Direct project but as we move forward it will also be important and many organizations are looking for that type of service. Now, I talked just a second ago about providing monetary assistance to help the organizations. And my suggestion is that we target those potentially underserved organizations and those organizations that service a lot of underserved patients. So that being said, FQHCs in the behavioral health community in the state have expressed interest in working with us and I think that that's a good place to target this money that we might have available and help them connect to Direct, help them with their vender issues as far as connecting and begin there to form this Direct community that we want to start and be part of the network effect that we hope to get.

So the network effect, if we go and help the FQHCs -- if we'd be able to help the community, they exchange with partners we would hope that those partners would then want to get on to Direct. We know that there are a number of EHR venders in the state who have Direct, Quest and Cerner. Others coming forward also, so we need

to put something in place to help stimulate that network effect and us doing it I think is a great way to help stimulate it. Long-term care pilot, this is an issue that's taking more and more of the spotlight at the federal level. There are a number of working groups at ONC dealing with, you know, what is the appropriate data to exchange between a long-term care patient when they leave that long-term care facility. We have potential partners already that we've talked to and are very interested in at least moving it one way to start. And that would be from a long-term care facility to say a hospital ED and that would be very valuable to the hospitalist in the hospital and the ED providers when those patients from long-term care facilities come in and they're looking for information on them.

So we have partners who actually want to do that with us and I think that that's another place, as I said, if we want to fund a couple of projects those are certainly one of them that we should look at. Cross data exchange with Rhode Island, so this is becoming more and more of an issue at the national level. States want to move data across state lines. Rhode Island has been very successful in the past at getting grant money, frankly very, very successful. And us partnering up with them

might help us potentially be able to participate in one of those grant opportunities, so that could be certainly good for HITE/CT.

The orchestrater approach, so capacity building jump starts the environment and that needs to happen first. What happens after we jump start the environment? So in the past about that thin layer query response-type environment where if I'm a provider in an office and I want to -- I get a patient in from, you know, somewhere outside the Health Information Exchange that I'm connected to. I would like to be able to pull that patient's record in. And we know that it is a referral pattern in the state certainly. I hear this from the guys at the hospital level that there are basically four organizations in the state that many of the other hospitals and other providers in the state refer to for various services which they can't provide themselves.

So Hartford Hospital, Connecticut Children's Medical Center, Yale and potentially St. Francis, a lot of cardiac patients get referred there. So let's, you know, think about when a patient does get referred to them from potentially let's say the New Haven area up to the Hartford area, we'd like to put in this query response mechanism. Well, we have connected those

two exchanges together so that when that patient shows up under the appropriate conditions and with the patient's consent, that a provider in Hartford could query the Yale exchange and pull information about that patient over to have available to him when he's taking care of the patient. Many other states, again, are looking at this as a phase two. Massachusetts just did a big -- sort of big article publication about Massachusetts's next step since they have their Direct stuff running now, their next step is to get this query response environment set up in Massachusetts to allow for that.

So the orchestrater approach, that thin layer that connects local Exchanges together, that's what the orchestrater does. And I think from our perspective going forward, even from a sustainability perspective, that is potentially where we could get some sustainability. You know, certainly that would be a service that the Exchanges, as they start to come up, would want to pay for. So to get this started -- and you know, I said 12 to 18 months. If we finish up early on the other stuff we'll start early. But we can gather some information first and that goes, again, around all of the consent policies that are in place because when we start to move between Regional Exchanges, right now in

Connecticut there is no one way to do consent. You know, for instance in New York it's an opt-in model. In Rhode Island it's an opt-in model. So patients must opt-in.

In Connecticut that's a possibility but opt-out is also a possibility and even under our policies opt-out with various exceptions and signing off is your right to opt-out. So the models could very greatly -- I don't know that we'll necessarily take a -- that the Legislature will necessarily take a position on that. But what we want to do is make sure that if we do exchange data between organizations that have different models, that we do it appropriately. So we need to look at how all of that works at each individual organization to come up with a way, strategy, to move forward to make sure that we have the patient's interest in mind when we do it, and again, at the public sector. So as I said, I think we are -- I think it is uniquely positioned to assist the public sector especially when it comes to connecting the public sector to the private sector.

So you can think of a situation at the Department of Social Services as the patient centered medical home project moves forward where DSS is going to want data. They're going to want to know what's happening to their patients. They're going to want to send that

data to their patient navigators to be able to appropriately care for the patient. How is that going to be set up? Is it going to be -- you know, certainly we -- and again, this is where I get to the issue of there needs to be some coordination around how this happens because if there isn't then potentially DSS would have to set up a separate link to everybody they want data to. And again, being from a infrastructure background that cost a lot of money to run and it's a constant issue to maintain it.

So we need to do this in a consolidated and efficient way for everybody and that's why I think we are very well positioned to do that. And we are going to get to the meaningful use, absolutely.

MS. KRAUS: Oh, yeah.

MR. DeSTEFANO: I put it on the list. Here's an interesting thing, and I do suggest that we do this. The Interoperability Working Group, which is a group out of New York but it's more than just New York that participates in this, there are 15 states, 19 of frankly the largest EHR venders and 18 Health Information Exchange venders, that are a part of this group. I never thought I'd see 18 Health Information Exchange venders because if you think about what needs to be done, I mean, why would you need 18.

But there are even more than that, there's over 100 I think now. But anyway, I've digressed here. So this is a group that's made up of a number of states, large EHR venders and the largest Health Information Exchange venders. What they've done is they've put together a set of technical specifications that define how EHRs and Health Information Exchanges should connect to each other. It's very standard space, it's not anything that the venders wouldn't be surprised at. And the venders have actually asked to have this -- asked to be part of this group. They want this to happen because from their perspective when they move into a marketplace and it's a marketplace that is part of this Interoperability Working Group marketplace, they know exactly what to expect. They know how they're going to connect to their partners.

So I think it's important that we in Connecticut say, this is how we want our marketplace to work too. And to do that, I don't know what the support from the public sector might be but certainly -- I'm sorry, from the private sector might be but certainly if we start at the public sector and if our Department of Public Health or Department of Social Services, our state CIO is willing to say this is the way we want this Health

Information Exchange to flow, this is the technology we're going to use so if you as a public company are going to go out and buy technology assets, here's how we're going to do it so you're not wasting your money. You know, it's well defined. And along with that after we do --

CHAIRPERSON MULLEN: I don't see Axway in this.

MR. DeSTEFANO: They are not in there, no.

CHAIRPERSON MULLEN: Sorry, just checking.

MR. DeSTEFANO: Yeah, you wouldn't find them there. So the collaborative working group -- I think this is important and there's some big words in here, Enterprise Architecture Blueprint. Really what it is, it is that thing that says here are the use cases that our Exchange supports in Connecticut. So that might be here's how we get surveillance data with DPH, here's how we get immunizations to DPH, here's how we communicate with the Department of Social Services when we want to send them a CCD for one of their patients.

So those types of use cases in an Enterprise Architect Blueprint are defined and the technology pieces that go along with them that tell you how to exchange the data, are defined in there. And that's something that's a public document that any public

and private agency or company can look at and say okay, if I have to participate in this marketplace I know what to do. It's well defined in this document. So I think that's an important document that we need to get out and frankly, in the 12 to 18 months it's me giving myself some time. I don't think we have that long. I think we need to get it out before then. I think we need to move this whole agenda to second target, the orchestration part of it forward, quicker.

Okay, so in closing I'm certainly hoping that all the recommendations that we have heard will be implemented. And it's not just me thinking this, there are other people who think like this. Any questions?

MR. CARMODY: Hey John, it's Dan.

MR. DeSTEFANO: Yes Dan.

MR. CARMODY: Is the -- on some of the things that you had mentioned are there fees or costs associates with doing those? It sounded as if a lot of these were things that we could join but, you know, just --

MR. DeSTEFANO: Yeah, so Rhode Island I think is our first and it has to be a priority for us. There are no fees. If you look at it from Rhode Island's perspective frankly it's good for both of us because this

does open the door to a number of grant opportunities which Rhode Island has been trying to foster with other states around exchange of information across state lines.

So this only helps them with that. And frankly, the way that our marketplace is set up there are no fees to join and they're even willing to rename it to the Connecticut/Rhode Island Direct marketplace, which I don't think is a bad idea because it does say its community and in all fairness to our position with ONC and -- you know, I think they would -- that would go well with ONC.

MR. CARMODY: And what's the downside?

MR. DeSTEFANO: I don't know, does anybody -- the downside is that we're not in total control of it anymore.

MS. ELLEN ANDREWS: That's true.

MR. DeSTEFANO: But with the Directtrust.org coming out with their accreditation, I don't know that anybody's really -- I think that will be in control of it in the next six months anyway. So there isn't really a I don't think a -- I don't think there's a real strong downside to this.

One thing we need to do, and I'll ask Bruce to look over the documents on their website concerning the

marketplace and the agreement -- you know, and frankly the agreement really at their marketplace with their marketplace is between whatever vender the organization or provider decides to pick and the provider. The marketplace really just sets up the environment for providers to have a place to go that the Direct marketplace says are trusted entities that you should do business with.

MR. CARMODY: Okay.

MR. DeSTEFANO: Yeah, I think the funding comes into place when we try to stimulate the environment and we look to certain organizations in the state who might be in a position to need some funding to help them get connected.

MR. CARMODY: And what about there was that standard, was there a standards organization I thought you talked about or again was that if we joined?

MR. DeSTEFANO: And that was -- Bruce, I think I asked you to look at the document, the memo of understanding from Interoperability Working Group?

MR. CHUDWICK: Oh yes.

MR. DeSTEFANO: Yeah. So what they are asking, there's no -- and again, they're very interested in getting another state signed up too. What they're

asking really is that you have a memo of understanding with partners in the state that you would put forward. And it's not -- you don't have to. If a private organization doesn't want to do it they don't have to do it, but it sets the groundwork for -- and you know again, it signals I think the community that this is the direction we're going in.

And the community, although they've sort of ignored us up to this point or tried to anyway, they're not going to be opposed to that. They would like to know any of these health care organizations around the state who are going out right now and spending frankly millions of dollars to put these Health Information Exchanges in. They'd like to know what the rules are going to be and how they're going to communicate with the state in the future. And if somebody would put that out there, I think they'd be grateful actually for it.

MS. PARKS-WOLF: A question about Rhode Island. So they're good at getting grants and there's a lot of business that you talk about that sort of jump starts the community.

MR. DeSTEFANO: Yes.

MS. PARKS-WOLF: Well, what does Rhode Island do to generate revenue?

MR. DeSTEFANO: Well, so the reason that it's good for us in Rhode Island I think is that if we get our Direct trust or our Direct marketplace set up then we don't have to do anything, which is always a good thing because it works and we know it works, it's already set up, we don't have to go through a lot of time and energy, frankly more time than the energy, of getting this set up.

How Rhode Island generates funds, grants, so they have Beacon grants, they have the HIE really not generated but they get grant funding. They have a voluntary, I think it still is, payer -- the payers in the state. So not necessarily just the insurers but the payers. So large companies in the state that are self-insured put in, and I don't remember the exact number --

MS. KRAUS: It's 13 cents --

MR. DeSTEFANO: -- 13 cents, something like that, towards Health Information Exchange and that money goes to RIQI.

MS. PARKS-WOLF: On a voluntary basis?

MR. DeSTEFANO: Voluntary basis right now.

MS. PARKS-WOLF: There's no legislation or anything?

MR. DeSTEFANO: It's in the legislation but it's -- there is legislation, yes. There is some kind of

legislation there but it's voluntary, you don't have to do it. But there is legislation in place to create the fund and everything that the money goes into.

MS. ANDREWS: Is the state one of those self-funded payers that they refer to?

MR. DeSTEFANO: I'm not -- I don't know but we can find out. We can find out who they are --

CHAIRPERSON MULLEN: We can find out.

MR. DeSTEFANO: -- yeah.

MS. ANDREWS: Both Medicaid and the State Employee plan is good to know.

MS. MINAKSHI TIKOO: Oh, okay.

MR. DeSTEFANO: Yeah, we can find out. I'll get back to everybody on that, I'm not exactly sure who.

CHAIRPERSON MULLEN: So we've talked about over time, we can go back to the conversation about our connection to the RAC and how the RAC plays into this bigger picture. So as we think about a relationship with Rhode Island how do we work with the RAC to keep moving forward?

MS. PARKS-WOLF: A new client.

MR. DeSTEFANO: So the REC, they have more resources than we do and they like us don't really have a

good sustainability plan. They go out and they see providers and then we ask them well, who did you see because now we want to go see them. So, you know, it doesn't make a -- it really doesn't make a lot of sense or it would make more sense if we sort of did a lot more things together. I think in some ways the differences in our organizational structure may rub against each other and make it harder to do that.

So moving forward certainly they've been more than willing to do things together, but our agenda and initiatives aren't necessarily theirs unless we are physically sitting there with them to make it theirs and for theirs to be ours. So, you know, I don't know barring that I'm not really sure exactly how we leverage that relationship other than asking them to help us when they do go to providers or at least let us know. You know, when are they going to visit the providers -- you know again, taking examples from other states. And I'm picking on Rhode Island because we just saw them -- we just went to visit them on Friday and so we got a lot of good information.

But the REC being part of RIQI has helped the Health Information Exchange because when they go and deploy the EHRs to the providers, at the same time they

sign them up at both Direct accounts and they train them now to use Direct. And if there's any system configuration that needs to be done, if they have a system that connects to Direct the REC takes on those jobs because the Health Information -- because there is no distinction I guess between the two. It's a real -- I mean you know, on paper there but in reality they work very much together to get the -- to move the projects forward.

MS. PARKS-WOLF: For the REC, you have meaningful use one and two --

MR. DeSTEFANO: Right.

MS. PARKS-WOLF: -- which is time limited and a grant to help to achieve that. So when that time limit is done and that grant is done, what other things do they --

MR. DeSTEFANO: So the REC is looking at various other opportunities but the opportunities they're looking at -- and popHealth is one of them. So popHealth is an ONC really funded project. It was built by Mider (phonetic) and what it does is meaningful use quality measures. So you feed the data into CCDs and it gives you quality measures. Well, what Mider built was for single organizations so what the Regional Extension Center is

doing in conjunction with Maine and Massachusetts, is building that system out so that you can say get a group.

Like say you -- you know, as an example the fairly qualified health center. Say they all -- they do have an organization. Say all of them wanted to feed that data into popHealth. Then you'd get metrics, comparative metrics across all of them. So that's one of the things they're looking at to funding themselves.

MS. PARKS-WOLF: Well I -- so you'd be able to track the same person between --

MR. DeSTEFANO: No, because the quality -- popHealth rolls it up at a higher level.

MS. PARKS-WOLF: -- higher level, yeah.

MR. DeSTEFANO: Yeah, so you could say how do I compare to this other FQHC, that type of thing.

MS. ANDREWS: That's typical.

MR. DeSTEFANO: Well yeah --no, it's -- but again, they haven't got a lot of attraction on it yet. But one of the big problems is they need CCDs and there's no way for them to get them right now. There's no way to connect so what we're supposed to be doing isn't in place for them to leverage, to do what they'd like to do to create sustainability.

CHAIRPERSON MULLEN: So the relationship is

with RIQI or with Current Care, which is the HIE?

MR. DeSTEFANO: Current Care is their vender.

CHAIRPERSON MULLEN: Right.

MR. DeSTEFANO: So, you know, it's just RIQI's vender basically.

CHAIRPERSON MULLEN: Okay.

MR. DeSTEFANO: And again, they have a -- other than a Direct infrastructure in Rhode Island they have a non-standard -- it's a non-standard base exchange so it works well. And so, you know, the whole issue around standards and everything -- you know, there are ways to leverage technology to get around that. So to build gateways that understand different types of protocols and languages basically to work around the standards issues and still be standard-based.

But what's in the back end can work however it wants to work. So that's the sort of direction that they're taking. They have Direct so they can get CCDs through Direct, put it in there and any -- you know, the whole Direct and CCD is all standards-based. But they're paying a lot so they have built a gateway there to take all of this standard stuff and move it into a place that isn't based on any of those standards but is still

functional and it does what they require it to do, which is pull patient records back when people want to see them.

MS. TIKOO: And formerly they started with a point-to-point, which is a good place to start. And, you know, they've been mature and they've been doing it now for at least three or four years and so now they're moving to where they're saying -- you know, you just have something happen. And you send us a CCD at that point rather than waiting for the point-to-point exchange which -- you know, is like for a reason a person, a provider, sends the CCD from one place all that information from one place to another place.

So it's driven by the person and it is governed by those rules. Where you might be faxing it today, you're sending it electronically and that's basically where the first place is, you know, simple implementations are. So instead of the doctor's office sending a fax they're sending a Direct message. And it's an easy sell, it's within the workflows of people. It makes it easy to convince people that it's a good way to use it and then make the next move if you will. So -- you know, so it's very focused on that point-to-point exchange which is what ONC would like to see happen in our state too.

CHAIRPERSON MULLEN: It's a great presentation. As I look at RIQI and their Board, it's just -- it's a lot for us to really look into how HITE/CT then partners with them if I look at all of what RIQI is. I'm not at all disagreeing with anything that you've provided but understanding more about who it is and what it is that we would be partnering with.

MR. DeSTEFANO: Right. Yeah, it's different organizations --

CHAIRPERSON MULLEN: There's a lot there --

MR. DeSTEFANO: -- yeah.

CHAIRPERSON MULLEN: -- and if RIQI was there then I'd want to understand even more what their interest in us is because there's so much more to be bought.

MS. TIKOO: And they've offered to come and speak to the Board -- if the Board wanted to talk to them directly they offered actually to come and answer any questions that the Board would have, so.

CHAIRPERSON MULLEN: And you're talking about the RIQI -- their Board, their leadership?

MS. TIKOO: The CIO and the direct person is Alice --

MR. DeSTEFANO: Nyberg.

MS. TIKOO: -- Nyberg, so they would be --

MR. DeSTEFANO: But, you know, I wouldn't -- you know, Laura Adams would probably come too.

MS. TIKOO: We didn't approach her so I didn't want to commit somebody to come --

MR. DeSTEFANO: Yeah.

MS. TIKOO: --but again, the people we were talking --

MR. DeSTEFANO: Yeah, it's a different kind of organization from us but it's successful.

CHAIRPERSON MULLEN: Oh yeah, successful. And the other reason that I find is interesting is because so early in the meeting we talked about what else it would take in the future for us to be able to move forward given the existing legislation that we live within. And while there's -- I think there's a lot of -- you know, our operations that we would finally address if we end up going through Direct Trust, etc., I also just have to think about not just me but it would be important of us to think about what else -- it sounds great.

MS. TIKOO: Yeah.

CHAIRPERSON MULLEN: I look at this as being so different legally, otherwise I need to understand how easy it will be in the meantime and what other hurtles

we have to go through. And maybe you already know they're not there.

MR. DeSTEFANO: Well I think --

CHAIRPERSON MULLEN: This is just such a different group and body --

MR. DeSTEFANO: -- right, so any provider in Connecticut right now could sign up with their Direct marketplace.

CHAIRPERSON MULLEN: Ahum.

MR. DeSTEFANO: It's not closed and since Direct is the point type of communication it's a communication that already exists, a provider that's already sending information just a different way. So it doesn't really -- as I said, the way their marketplace is set up it doesn't preclude any other provider from any other state joining it.

CHAIRPERSON MULLEN: Ahum.

MR. DeSTEFANO: But I think from our perspective it gives us sort of a jump start and that one -- you don't have to go through all the time frankly to set it up, it's already set up for us.

CHAIRPERSON MULLEN: Ahum.

MR. DeSTEFANO: And as I said, they are willing to change the name even to reflect that

Connecticut would be part of this. And growing in the country, I mean this is not -- look like the western states consortium, not to the extent of this. But there are other initiative going on around the country where Health Information Exchanges are sort of joining forces together because they understand the issues of sustainability and the future issues about moving data between state lines. So --

MS. TIKOO: And Directtrust.org is also more evolved over time --

MR. DeSTEFANO: Right.

MS. TIKOO: -- to the point that they will be the body that maintains the security and privacy policy, the standards. There's going to be accreditations so, you know, if a HISP has been accredited by Directtrust.org you're really not publishing a standard you're just saying, you know, if you're going to be accredited by this body then you can do business in Connecticut.

So essentially the whole process that you have where you had to make sure that people were doing what they said, this accreditation takes care of that piece where you don't have to maintain that for it because you know, you have a national body that has been set in

the statute and they're doing it for you basically. And that's all ONC funding, that work is all ONC funding. And you know, Rickey actually has a contract to do the, you know --

MR. DeSTEFANO: Actually Rickey has the -- is their the contractor for Directtrust.org.

MS. TIKOO: Yeah, they maintain.

MR. DeSTEFANO: They do the paperwork.

MS. PARKS-WOLF: So it's an issue of how the two Boards do joint decision-making on this project?

MR. DeSTEFANO: I think we limit it to in scope to just the Direct marketplace.

MS. TIKOO: Yeah, yeah, we don't do any of that.

MR. DeSTEFANO: And then, you know, I can't see anything that they're doing that we wouldn't absolutely do ourselves so it's not different.

CHAIRPERSON MULLEN: No, I want what they have.

MS. TIKOO: Me too.

CHAIRPERSON MULLEN: I mean, it looks great. It's a nice website to look at and start to familiarize yourself more about what you're talking about.

MS. KRAUS: It's very user friendly.

MS. TIKOO: Yeah.

MR. DeSTEFANO: So moving forward, I know probably there will be some opinion that you might as you think about this, you might want to bring back. I'd like to get started on it because as I said -- and I truly believe the runway is -- we're running out of runway because these things do take time as we've found to grow and we need to get it started.

So certainly I'd like to pursue the Rhode Island relationship and after Bruce has had a chance to look at the documents --

MR. CHUDWICK: The due diligence on it.

MR. DeSTEFANO: -- right, I'd like to pursue that relationship at least to start. We also have some pilot projects that we'd like to pursue and I'd like to borrow maybe from the Oklahoma model around how they have granted out monies to fund some of those projects.

So we know what the marketplace is going to look like, we know it's going to be about $10 a provider. So if we can come up with $120 a provider per year and we can find as many as we can find -- it could be -- you know, if we get 100 or 200, especially in the F2HCs and the behavioral health community, I'd like to move with those projects and I'd like to start doing some initial

work on what the structure of those would look like.

CHAIRPERSON MULLEN: And you need the Board approval for that to be able to come back to --

MR. DeSTEFANO: Right.

CHAIRPERSON MULLEN: -- DPH to ask within the contract to be able to use the monies that way.

MR. DeSTEFANO: Right, right.

MS. ANDREWS: I have a couple of questions on that and the long-term care. On long-term care it was my understanding, and this was awhile ago, that long-term care facilities don't tend to have electronic records. Is that not the case or do you have partners who are interested who do have it?

MR. DeSTEFANO: Right.

MS. ANDREWS: I just worry that we're going to get the few that do and we're not going to have some things assembled to the rest of that great pilot that won't be able to be --

MR. DeSTEFANO: So here's who we know does have it and that's the Genesis. I think there's Sun Healthcare, I think that's gone so that could make Genesis the largest nursing home company in the country.

MS. ANDREWS: Right.

MR. DeSTEFANO: There are 14 Genesis sites

in Connecticut right now and they're sort of all around the place --

MS. ANDREWS: And what do they have?

MR. DeSTEFANO: -- they have an EHR.

MS. ANDREWS: Oh, they do have an EHR.

MR. DeSTEFANO: Yup.

MS. ANDREWS: All 14 sites have it?

MR. DeSTEFANO: All 14 sites and I talked to their -- he's actually the gentleman who does their special projects and he's been very involved at ONC with the S&I framework around what that data should look like when it moves from a nursing home out or from a nursing home -- or from some place else into a long-term care facility. And they're very interested in doing a pilot and as it regards to that I've talked to Hartford Hospital and St. Francis and the Genesis site in Windsor and both Hartford and St. Francis are interested in seeing those records come in when patients move from the nursing home for whatever reason to the ED or to an inpatient setting at one of those hospitals.

So it does give us an initial pilot site -- or some initial pilot sites to work with. When the data -- we wanted to do it both ways but the data moving back the other way, all of those sites have an Allscripts

product right now that they use to move data from the inpatient setting to the nursing home. So it's a pretty popular Allscripts product. But again, pilots are -- we don't know the sustainability really in the long run but we can at least suggest anyway that this is becoming a growing issue in the country as the dollars that are spent on long-term care are astronomical. So certainly to get better data flow there and a pilot project is -- we wouldn't frankly other than funding the initial setup of it, after that it's the partners themselves that would continue to purchase Direct services, it wouldn't be us.

And we would fund them for a year and then after that if they want to continue --

MS. ANDREWS: And I'm not saying for 14 sites in Connecticut that's still -- even if they never went any further it just might be worth having a conversation with the two different organizations to see whether there would be other nursing home sites in Connecticut that would be interested if this is successful --

MR. DeSTEFANO: Yeah.

MS. ANDREWS: -- or if they're like, you know, forget it.

MR. DeSTEFANO: Yeah, part of the -- so

here's part of my problem. It's not -- it is what it is quite frankly. There's only Chris and I so we have to pick some things that we think are really doable that we can achieve.

CHAIRPERSON MULLEN: So here's -- you know, one of the things I would ask is what's the desired outcome of the pilot and is it to think that people -- you'll -- they will lower admission rates or --

MR. DeSTEFANO: Yeah, we --

CHAIRPERSON MULLEN: -- and what you might do and what I might offer you in just the time is to also talk to the health care facility staff who are also very linked to the whole association of long-term care providers and --

MR. DeSTEFANO: Is that DPH?

MS. TIKOO: Yeah.

MR. DeSTEFANO: It is, I didn't know that. You didn't tell me Minaskshi. Okay no, that's good, yeah.

CHAIRPERSON MULLEN: Yeah, we license nursing homes and we're, through CMS, responsible for quality. And I think in configuring a pilot we would want to start some place beyond what CMS already mandates.

MR. DeSTEFANO: Right.

CHAIRPERSON MULLEN: So just -- you might

-- there might be some other conversations to be had so then -- if I think about it as a position and think about all the reasons for readmission. The other thing I would ask myself in the pilot is, is that where the biggest issue is so that if we want to look at what the biggest bang for the buck is for Exchange, whether or not that's in. Because -- and Qualadine has been working with -- are you part of the Quality and Health Care Committee at Qualadine also?

MS. ANDREWS: I don't think so.

CHAIRPERSON MULLEN: No -- maybe you are --

MS. ANDREWS: I don't go if I am, so I don't know anything about it.

CHAIRPERSON MULLEN: -- alright, is also looking at this. So I can put you in some directions --

MR. DeSTEFANO: Yeah.

CHAIRPERSON MULLEN: -- so that it doesn't just have to be you --

MR. DeSTEFANO: That will be great.

MS. ANDREWS: And I also had a question about behavioral health just because of privacy and we talked about behavioral health. And also Health Information Exchange, while it's not just about primary care that is -- you know, it's part of patient center

medical homes and the idea of linking things through a medical home. I'm just wondering if our -- I got to tell you it warmed my heart that you're going to start with the underserved populations. It made me very happy. So I think F2HCs make a lot of sense but the behavioral health side of it, I'd just like to -- maybe not here right now but talk to you more about how that would work.

MR. DeSTEFANO: Okay.

MS. ANDREWS: Just because it's such a sensitive issue and it is -- you know, it's not primary care.

MR. DeSTEFANO: Yup.

CHAIRPERSON MULLEN: Do you -- so minimally have you gotten the go ahead from the Board to at least continue the conversations?

MR. DeSTEFANO: I have not.

CHAIRPERSON MULLEN: Do we need a motion for that?

MR. CHUDWICK: Yes, you do need a motion for that.

CHAIRPERSON MULLEN: So we need a motion to encourage you or allow you to continue a no commitment --

MR. DeSTEFANO: Yeah --

CHAIRPERSON MULLEN: -- conversations with

Rickey.

MR. DeSTEFANO: -- right.

CHAIRPERSON MULLEN: Rhode Island Quality Institute. Can I move that? I move that we have John and Chris on behalf of HITE/CT continue the conversations with RIQI as Bruce Chudwick does his other due diligence looking at our contracts to enable us to then have you get more information, come back with a formal recommendation that would then enable you to come back to DPH in the event that we need to seek an amended contract for HITE/CT to go forward if there are fiscal implications for what we need to admit. How's that?

So yes, so I move that you have a conversation.

MR. CHUDWICK: Is there a second?

MR. HEUSCHKEL: Which I will second.

CHAIRPERSON MULLEN: Sorry that that was so long.

MR. CHUDWICK: No, that's okay. Any discussion about the motion? Okay, all in favor of the motion please signify by saying Aye.

ALL VOICES: Aye.

MR. CHUDWICK: Those opposed say no. Any abstentions? Motions carry, okay.

MR. DeSTEFANO: Just one comment there on that. So, you know, our Board meets monthly which again, from the prospective of wanting to be agile and move quickly is a problem. We potentially could get this done before the next Board meeting. They really have potential, I mean, they're very interested in working with us and they're willing to put resources here to -- you know, to figure out any issues that we might have with it.

So approval of anything as far as change from the DPH prospective, how will we handle that if we are ready in two weeks or so? This is a key piece for us to get going I think.

CHAIRPERSON MULLEN: Well, first you'll need Board approval around whatever you would be -- whatever monetary changes, physical changes.

MR. DeSTEFANO: I don't foresee any for the Ricky thing.

CHAIRPERSON MULLEN: Alright. Well, another piece of it might be what else ONC says to DPH about our --

MR. DeSTEFANO: Right.

CHAIRPERSON MULLEN: -- present status with that. We could do a phone meeting if necessary or we could ask the Executive Committee with that.

MR. CHUDWICK: That's been done before that the Board often delegates a certain authority to the Executive Committee between meetings -- fiscal implications and that just sounds like it's something very interesting of all Board members. So maybe once steps are completed and you're well along the way there could be a Executive Committee meeting and then --

MR. DeSTEFANO: Move it forward that way.

MR. CHUDWICK: -- right, it would be teed up for final approval with the Board at the next meeting at the very latest. Would that work?

MR. DeSTEFANO: Um --

MR. CHUDWICK: Otherwise we could amend the motion to provide the Executive Committee to delegate --

MR. DeSTEFANO: Could we do it -- could we have the motion be that the Executive Committee thinks it's appropriate to move it forward before the next Board meeting, that we just go ahead and do that? Yeah, you know my -- we need to show signs of life pretty soon as an organization, so.

MS. PARKS-WOLF: Or have a special Executive Committee meeting.

MS. MARIANNE HORN: A special Board meeting?

MS. PARKS-WOLF: I'm sorry, Board meeting.

CHAIRPERSON MULLEN: Well, we could do that.

MS. MATTIE: Would it require signing a contract or just vote for funds?

MR. DeSTEFANO: You know, it's not really us signing a contract with them it's us adopting their -- what they have in place for structure, which is just a couple of documents. Again, the relationship between somebody who's part of the Direct marketplace is between the Direct marketplace vender and the provider, whoever signed up. What the Direct marketplace does really is just say, you know, these are the providers -- these are venders that have come to us and they're following all the rules so you can use these venders.

MS. MATTIE: The only suggestion -- just in light of everything that's going on I just -- and also hearing you in terms of wanting to move forward, I would feel more comfortable if there was a special meeting of the Executive Session and -- with some legal consult --

MR. DeSTEFANO: So Executive Committee --

MS. MATTIE: -- advice at that time once you've hammered the business perspective and what you want in terms of contractual terms or things like that. I

think that's probably -- as opposed to us just saying move forward with --

MR. DeSTEFANO: No, that wasn't my -- my intention was to have -- to do it through the Executive Committee if possible.

MS. MATTIE: I certainly understand that but in light of the external factors right now, I think it would be best to have a special meeting of the Executive Session --

MS. HORN: Executive Board?

MS. MATTIE: -- Executive Board, right, with some legal consult at that time.

MR. DeSTEFANO: I mean, I certainly think that's appropriate if everybody else does.

MR. CHUDWICK: We need a round of approval. We already voted on the motion as approved. And that's what you'd do, it would be a motion to reconsider what was just voted on. Need a motion and second to reconsider, you can put it back on the table and amend it to include that.

MS. MATTIE: Okay, I mean the way I understood it was yes, have the discussions, come up with some business terms in those discussions and then get approval to go into some sort of business venture to meet

with the Executive Committee.

CHAIRPERSON MULLEN: So moved to reconsider the original motion that was voted on.

MR. CHUDWICK: Motion to reconsider, we need a second to do that.

MS. PARKS-WOLF: Second.

MR. CHUDWICK: Any discussion? All in favor of the motion to reconsider please signify by saying Aye.

ALL VOICES: Aye.

MR. CHUDWICK: Opposed say no. Motions carry. Okay, now you can make a motion to amend what you just did. So, it will be the same motion --

MS. MATTIE: The amendment would be once any business terms are decided between the Rhode Island entity and us at a special session be called at the Executive --

MR. CHUDWICK: Committee.

MS. MATTIE: -- Committee with legal counsel present.

MS. ANDREWS: Can I ask a question? Are you concerned about our legal position because I think -- is it possible to say that that be taken into consideration, that the Board just wants the Executive

Committee to consider that?

CHAIRPERSON MULLEN: And in terms of all external factors, so I second your amendment to the original motion.

MR. CHUDWICK: Okay, so there's a motion and second to amend it for that purpose. Any further discussion? All those in favor please signify by saying Aye.

ALL VOICES: Aye.

MR. CHUDWICK: Opposed say no. Motions carry, okay. So I think we are what you need today.

MR. DeSTEFANO: Thank you.

CHAIRPERSON MULLEN: It's nice work.

MR. DeSTEFANO: Thank you.

MS. PARKS-WOLF: John, could you send that PowerPoint so we --

MR. DeSTEFANO: I -- yeah.

CHAIRPERSON MULLEN: It's not PowerPoint.

MR. DeSTEFANO: I have -- what we'll do is -- yeah, we'll distribute to everybody. The PDF doesn't look as nice as the screen flying around all over the place but there's a PDF, yeah.

MS. PARKS-WOLF: Thank you.

MR. DeSTEFANO: Yup.

MS. PARKS-WOLF: It looks nice in a draft.

MR. DeSTEFANO: Yeah, especially late at night --

CHAIRPERSON MULLEN: Speaking of late at night --

MR. CHUDWICK: Is there anything else? And so that's for Ricky, that proposal. Then we also said something about pilot projects, was there something with that?

MR. DeSTEFANO: So we are currently working with the Department of Social Services on a pilot project. That pilot project would require us to have participants who have Direct. Our intention is to put this marketplace forward and have those participants choose from one of the available venders that are part of the marketplace. So that's why, you know, my sort of rush -- I don't want to do anything foolish, but rush to get this in place so that we can, again, move those pilot projects forward.

MS. PARKS-WOLF: And our role in that is?

MR. DeSTEFANO: Our role in that is a facilitator so we don't have infrastructure. We'll facilitate the flow of that information. So we will provide technical assistance to the participants to help them put their -- get their systems in line so that the

data moves.

MR. CHUDWICK: That's not the RSQ --

CHAIRPERSON MULLEN: And that's the transitions of care pilot that DSS is interested in, readmissions rate?

MR. DeSTEFANO: Correct, readmission.

MR. HEUSCHKEL: Readmission.

CHAIRPERSON MULLEN: Yes, readmission so that would be working with hospitals and --

MR. DeSTEFANO: We need to -- yeah and again, we don't really have anything set yet. We have a meeting coming up --

MR. HEUSCHKEL: Yeah, we're going to discuss it more.

MR. DeSTEFANO: -- yeah, but certainly this puts the foundation in place to be able to do something like that. So yeah, you'd --

MR. CHUDWICK: You're looking for a motion along the same lines as the Commissioner just said, authorizing you to pair that information, come back to the Executive Committee for a final decision to move forward, is that --

CHAIRPERSON MULLEN: I would like to hear from DSS on that one also.

MR. DeSTEFANO: Okay.

CHAIRPERSON MULLEN: To hear what DSS is thinking.

MR. DeSTEFANO: Yeah, and we haven't had that discussion --

MR. HEUSCHKEL: That's what I was just saying, we really haven't met with that group.

MR. CHUDWICK: Is that preliminary?

CHAIRPERSON MULLEN: It sounds preliminary.

MR. DeSTEFANO: So we'll proceed and we'll continue on the preliminary road there. So the other item was the -- probably one more contentious, the request for RFQ information --

MR. CHUDWICK: Which has been conformed or changed to an RFQ --

MR. DeSTEFANO: -- RFQ --

MR. CHUDWICK: for Direct.

MR. DeSTEFANO: -- right.

MR. CHUDWICK: John and I have been working together on a form of an RFI/RFQ and he provided a first draft, I revised it to make sure that it was compliant with the Freedom of Information provisions and so forth. This will be a formal RFQ to the public for Direct services, so --

MR. DeSTEFANO: And it's just really a -- you know, what venders might be interested in Connecticut in participating in the Direct community in Connecticut. So, you know, we -- again, and I think the Board feels the same way, we have no intentions of buying a product to offer through HITE/CT currently to provide those services but just to create a marketplace. So I'd like to put that RFQ out --

MS. ANDREWS: How does that fit with the Rhode Island piece?

MR. DeSTEFANO: Well see, I don't -- there may be venders and I'd frankly like to know who's out there and who's interested in Connecticut because in that -- if there are venders that might be interested who haven't already joined the Rhode Island marketplace for one reason or another because -- and I don't know what those reasons might be, but for them to know that if we're going to do this in Connecticut we'd like to know who you are so we can potentially point you in the right direction.

CHAIRPERSON MULLEN: I see you as trying to generate options and your stamp on a short runway.

MR. DeSTEFANO: That's right. You know, I used to -- the runway thing, I used to fly little planes

and there's no scarier feeling than seeing the threshold lines coming up on you and your plane -- your wheels haven't hit the ground yet. So the runway is short.

CHAIRPERSON MULLEN: And I think the aircraft carrier is slow.

MR. CHUDWICK: So the motion would be to authorize John to go forward with an RFQ for direct services in consultation with us and getting that posted for public --

MS. ANDREWS: Can we also do the legal consultation on that as well to see how -- that's our legal position?

MR. CHUDWICK: And that was the reason for some of the discussions today.

MS. ANDREWS: Yeah.

MR. CHUDWICK: So -- but yes --

MS. ANDREWS: And not just legal but also strategy.

MR. CHUDWICK: -- right, in consultation with outside counsel for that. We'll make sure we get that through and talk to them about that. Is there a motion to that effect?

CHAIRPERSON MULLEN: So moved.

MR. CHUDWICK: Moved by the Commissioner,

is there a second?

MR. HEUSCHKEL: Can we just summarize, I'm sorry, exactly what the motion is?

MR. CHUDWICK: This would be to authorize John to go forward with the publication of an RFQ for Direct services in consultation with legal counsel for those services.

MR. HEUSCHKEL: Okay, so this is just to okay it without any further --

MR. CHUDWICK: Right, we put together a document that I've black lined and he and I have worked on that is a basic description -- I don't know if you have a copy of it with you John?

MR. DeSTEFANO: The lined one, yeah.

MR. CHUDWICK: It's a description of --

CHAIRPERSON MULLEN: But it's not a planned approach we're servicing.

MR. DeSTEFANO: No --

MR. CHUDWICK: It's just like a request for qualifications and who's out there to provide this information.

MR. DeSTEFANO: Who's out there and who might be interested in doing -- in providing Direct services in Connecticut.

MR. HEUSCHKEL: Okay.

MR. DeSTEFANO: As we finish to try to line ourselves up with Rhode Island, we need to know who is in Connecticut right now who might respond to this and already -- there might be some venders out there already doing this or there might be some interested in Connecticut, so.

MS. ANDREWS: Is there any way to call it a survey instead of RFQ. It just sounds less --

MR. CHUDWICK: Well, but it really is a -- you know, in the public sector there are RFQs and RFPs, the standard nomenclature. We had started with an RFI but -- and that was maybe in the private sector perhaps but --

MS. PAKULIS: Why not an RFI, I'm sorry?

MR. CHUDWICK: Well because this really is a request from your qualifications.

MS. PAKULIS: I see.

MR. CHUDWICK: Tell us about you as a business that you can provide Direct services. And that's all it is, just tell us about the company.

MS. PAKULIS: Okay.

CHAIRPERSON MULLEN: Like an environmental --

MR. CHUDWICK: Right.

CHAIRPERSON MULLEN: The reason I was comfortable moving this was that months ago the Board decided to pursue Direct and so here we are in Connecticut and we need to know who can do Direct.

MR. DeSTEFANO: And we don't know --

CHAIRPERSON MULLEN: So that's -- right.

MR. HEUSCHKEL: So do you need a second still?

MR. CHUDWICK: Yes, we do.

MR. HEUSCHKEL: Okay, I'll second.

MR. CHUDWICK: Okay, Mark seconds. A motion and second, further discussion?

MS. VANELLA KAPRAL: I have a question. Is it possible friends we know could respond to that RFI?

CHAIRPERSON MULLEN: It's an RFQ.

MS. KAPRAL: RFQ, sorry.

MR. DeSTEFANO: Sure.

MS. KAPRAL: Okay, so friends we know could respond to that --

MR. DeSTEFANO: And if -- you know, what Axway has for Direct right now, if they --

FEMALE VOICE: If they want it?

MR. DeSTEFANO: -- no, they wanted it but quite frankly, you know, as far as we know what they have

really isn't that. If they wanted to respond, anybody can respond to it.

MS. KAPRAL: Okay, thanks.

MR. DeSTEFANO: And if some point in the future they want to provide services and they have customers, absolutely.

MR. CHUDWICK: Okay, further questions? It's been moved and seconded, all in favor of the motion please signify by saying Aye.

ALL VOICES: Aye.

MR. CHUDWICK: Those opposed say no. Any abstentions? Motions carry, okay. Does that do it --

MR. DeSTEFANO: I think I have enough to get through.

CHAIRPERSON MULLEN: So I'm ready to move that, unless there's something pressing in other business Committee updates, we go straight to public comment.

MR. CHUDWICK: Miss -- hello?

MS. KAREN PATROWSKI: Yeah, I've been listening to everything --

CHAIRPERSON MULLEN: Hello, I don't know your name. How are you?

MS. PATROWSKI: I'm Karen Patrowski, I --

COURT REPORTER: Can you actually come up

in front of a microphone?

CHAIRPERSON MULLEN: And welcome and thank you for staying so long.

MS. PATROWSKI: I am part of the public sector, I guess on the patient side or whatever. But I also received my Master's degree in medical informatics from Northwestern University. And so I just wanted to say a couple of things that -- just suggestions for the vender for the Direct marketing.

CMS has already decided on some venders that have made their -- to make sure that they have met a lot of the requirements. So you may want to look at that to see if they're on the vender's list because I would think that if you wanted Direct marketing on your website or whatever that you may want to make sure that they have that minimal connectivity, like they're using Health Level-7 and other things, just to make sure that maybe they're just providers that you know that they've met the minimal requirements so some health care organizations don't choose the venders that don't meet those requirements.

So it would be a place for the Connecticut to actually go to all the health care organizations.

MR. DeSTEFANO: So it's good as a resource

if you -- actually I can give you my contact information that's on our website but if you could send me the link that -- what is CMS's that would be great --

MS. PATROWSKI: Okay yeah, sure.

MR. DeSTEFANO: -- that would be great just to see who they've -- because that might be very interesting for us even to go and approach the vender actually.

MS. PATROWSKI: Yeah, I'm just thinking --

MR. DeSTEFANO: And it would be part of our marketplace.

MS. PATROWSKI: -- that that would be something good for -- and again, I heard a little bit about Rhode Island, what is in it for them. And it's a big thing for them because if they can connect in with one other state, then they can market that and then other states that haven't coordinated with any other states can't come in and say you have to now do us -- you know, do things with us the way that -- so Rhode Island has come up with some really good techniques and they probably don't want other states to not use their technique.

So if you have two states starting to form a health care organization -- an HIE, then you're going to have a bigger bang for the buck and then Connecticut and

Rhode Island together can then propose to other states to get into the bandwagon with them.

MR. DeSTEFANO: Ahum.

MS. PATROWSKI: And I think that this is a really good approach that you're proposing right here. So I just wanted to --

MR. DeSTEFANO: I think in the future too we're going to see hopefully -- I know the Maine guys in New England, there's a western state's consortium right now, but I think we're going to see a New England one pretty soon. We have to get our neighbors to the north to think that the rest of us are important enough to participate.

But yeah, I think we're going to see that because I know -- right now Massachusetts is very busy building theirs up but as soon as they're done -- you know, there is -- I've heard from other HIEs in New England that this is something that we want to do, so.

MS. PATROWSKI: Yeah, because most of the people in my program at Northwestern, they were centered in Chicago to California and even Alaska. I was one of the few on the east coast that participated in the program and it was just -- you know, so I know that really the west coast and the central west was really doing a lot

more advanced work than the east coast was. But it's great to see that Rhode Island and Maine are really -- I don't remember anyone in Maine being at Northwestern's program, so -- you know, that's good.

CHAIRPERSON MULLEN: Thank you very much. We need a motion to adjourn.

MS. MATTIE: So moved.

MS. ANDREWS: Second.

CHAIRPERSON MULLEN: Thank you.

MS. KRAUS: Who seconded it?

MS. ANDREWS: Ellen.

(Whereupon, the meeting was adjourned at 7:21 p.m.)